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SENATE BILL 264
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AN ACT to amend Tennessee Code Annotated, Title 56, Chapter 7, Part 10, relative to downcoding and bundling procedures on health insurance claims.

WHEREAS, some health insurance entities will “bundle” claims submitted by a healthcare provider reflecting two or more separate and distinct Current Procedural Terminology (CPT) services as determined by the American Medical Association and reimburse just one of the services or procedures, without consideration of the actual clinical encounter between the healthcare provider and the patient; and

WHEREAS, some health insurance entities use “black box” coding edits that ignore certain modifiers or group certain CPT codes together contrary to CPT instructions and will often keep these edits secret because they are deemed proprietary; and

WHEREAS, some health insurance entities unilaterally reduce or “downcode” the CPT code submitted on a claim by the healthcare provider without any clinical basis and subsequently reimburse the healthcare provider at a lower rate; and

WHEREAS, downcoding and bundling practices arbitrarily ignoring nationally-recognized CPT instructions undermine the concepts of uniformity and fairness in payment systems; and

WHEREAS, the Centers for Medicare and Medicaid Services decided in 2000 to eliminate “black box” edits in the Medicare program; and

WHEREAS, national health insurers, Aetna and Cigna, have settled national lawsuits and have agreed to, among other things, disclose their edits to physicians and not automatically adjust or downcode claims beyond those that its plan providers are aware of through disclosures on their provider websites; and

WHEREAS, Blue Cross and Blue Shield of Tennessee and Aetna have voluntarily placed their coding guidelines on their respective websites so that payment logic, payment process and fee schedules are accessible to participating healthcare providers; now therefore BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding Sections 22 through 5 as a new part.

SECTION 2. As used in this part:

(1) "Healthcare provider" means any person or entity performing services regulated pursuant to title 63, whether a currently participating provider or a provider who is considering becoming a participating provider in the network of the health insurance entity.

(2) "Health insurance entity" means a health insurer, health maintenance organization or any other entity that delivers, administers or assumes risk for healthcare services with systems or techniques to control or influence the quality, accessibility, utilization or cost and prices or such service to a defined enrollee population.

SECTION 3.

(a) A contract or provider agreement between a health insurance entity and a healthcare provider shall provide that:

(1) At any time, the healthcare provider may request a copy of the coding guidelines, including any underlying bundling, recoding or other payments logic, edits and payment process applicable to specific procedures that the healthcare provider will receive under any contract to provide health care services;

(2) The health insurance entity or the health insurance entity's agent shall provide the guidelines not later than the thirtieth (30^{th}) day after the date of the request. The commissioner of commerce and insurance may impose and collect

a penalty of up to one thousand dollars ($1,000) for each failure to provide the requested information or to provide it in a timely manner;

(3) The health insurance entity will provide written notice in correspondence addressed and mailed to the healthcare provider of material changes to the coding guidelines, notes, payment logic, edits and fee schedules not later than the thirtieth (30th) day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee schedules; and

(4) The contract may be terminated by the healthcare provider on or before the thirtieth (30^{th}) day after the date the healthcare provider receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans of the health insurance entity.

(b) A healthcare provider who receives information under subsection (a) may use or disclose the information only for the purpose of practice management, billing activities, or other business operations. The commissioner of commerce and insurance may impose and collect a penalty of up to one thousand dollars ($1,000) for each use or disclosure of the information that violates this subsection.

(c) A health insurance entity which places the information required to be provided pursuant to subsection 3 (a) (1) and (2) on its website and makes the information readily accessible to participating and prospective healthcare providers will have been deemed to have met the requirements of this part.

SECTION 4. Health insurance entities shall pay claims according to nationally recognized, generally accepted American Medical Association current procedural terminology (CPT) codes, notes and guidelines, including all relevant modifiers.

SECTION 5. Information disclosed pursuant to this act shall not be interpreted as a violation of copyright or other laws in the disclosure of licensed, proprietary software.

SECTION 6. This act shall take effect July 1, 2005, the public welfare requiring it.